



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
5501 S MCCOLL RD
EDINBURG TX 78539

Respondent Name

Texas Mutual Insurance Co

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-13-0531-01

MFDR Date Received

October 22, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: \$1,799.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor states payment is due for code 29879. Texas Mutual does not agree. The surgeon who performed the surgery did not bill code 29879 or document that procedure in his operative report."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2012	Outpatient Hospital Services	\$1,799.65	\$1,799.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated July 11, 2012

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

- CAC-59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES
- CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
- 305 – THE IMPLANT IS INCLUDED IN THIS BILLING AND IS REIMBURSED AT THE HIGHER PERCENTAGE CALCULATION.
- 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE PLUS A MARKUP
- 615 – PAYMENT FOR THIS SERVICE HAS BEEN REDUCED ACCORDING TO THE MEDICARE MULTIPLE SURGERY GUIDELINES.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 767 – REIMBURSED PER O/P FG AT 200%. SEPARATE REIMBURSEMENT FOR IMPLANTABLE INCLUDING CERTIFICATION NOT REQUESTED PER RULE 134.403(G).
- 892 – DENIED IN ACCORDANCE WITH DWC RULES, AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.
- 894 – HCPCS/CPT CODES REQUIRED TO DETERMINE MAR. SERVICE NOT REIMBURSABLE AS BILLED.

Explanation of benefits dated July 17, 2012

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-18 – DUPLICATE CLAIM/SERVICE.
- CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
- 224 – DUPLICATE CHARGE.
- 305 – THE IMPLANT IS INCLUDED IN THIS BILLING AND IS REIMBURSED AT THE HIGHER PERCENTAGE CALCULATION.

Explanation of benefits dated August 13, 2012

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- CAC-18 – DUPLICATE CLAIM/SERVICE.
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
- 224 – DUPLICATE CHARGE.
- 305 – THE IMPLANT IS INCLUDED IN THIS BILLING AND IS REIMBURSED AT THE HIGHER PERCENTAGE CALCULATION.
- 723 – SUPPLEMENTAL REIMBURSEMENT ALLOWED
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES FOR INFORMATION CALL 1-800-937-6824

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation

used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75
- Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$14.97. 125% of this amount is \$18.71
- Procedure code 85027 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$9.17. 125% of this amount is \$11.46
- Procedure code 81001 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$4.48. 125% of this amount is \$5.60
- Procedure code 29879 was denied with denial code “892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINES INCLUDING CURRECNT CPT CODE DESCRIPTION/INSTRUCTIONS”. Review of the submitted documentation, “Operative Report” indicates, “We proceeded to do an abrasion chondroplasty on the medial femoral condyle...” The Procedure code 29879 description is as follows, “Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture.” The division finds the insurance carrier’s denial is not supported. Therefore, this service will be reviewed per applicable rules and fee guidelines.

Procedure code 29879 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of \$2,076.45. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,245.87. This amount multiplied by the annual wage index for this facility of 0.8824 yields an adjusted labor-related amount of \$1,099.36. The non-labor related portion is 40% of the APC rate or \$830.58. The sum of the labor and non-labor related amounts is \$1,929.94. The cost of these services

does not exceed the annual fixed-dollar threshold of \$1,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$964.97. This amount multiplied by 200% yields a MAR of \$1,929.94.

- Procedure code 29881 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0041, which, per OPSS Addendum A, has a payment rate of \$2,076.45. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,245.87. This amount multiplied by the annual wage index for this facility of 0.8824 yields an adjusted labor-related amount of \$1,099.36. The non-labor related portion is 40% of the APC rate or \$830.58. The sum of the labor and non-labor related amounts is \$1,929.94. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$964.97. This amount multiplied by 200% yields a MAR of \$1,929.94.
 - Procedure code 29888 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0052, which, per OPSS Addendum A, has a payment rate of \$6,212.62. This amount multiplied by 60% yields an unadjusted labor-related amount of \$3,727.57. This amount multiplied by the annual wage index for this facility of 0.8824 yields an adjusted labor-related amount of \$3,289.21. The non-labor related portion is 40% of the APC rate or \$2,485.05. The sum of the labor and non-labor related amounts is \$5,774.26. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPSS payment and also exceeds the annual fixed-dollar threshold of \$1,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPSS payment. Per the OPSS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.164. This ratio multiplied by the billed charge of \$7,906.49 yields a cost of \$1,296.66. The total cost of all packaged items is allocated proportionately across all separately paid OPSS services based on the percentage of the total APC payment. The APC payment for these services of \$5,774.26 divided by the sum of all APC payments is 74.95%. The sum of all packaged costs is \$3,855.78. The allocated portion of packaged costs is \$2,889.89. This amount added to the service cost yields a total cost of \$4,186.55. The cost of these services exceeds the annual fixed-dollar threshold of \$1,900. The amount by which the cost exceeds 1.75 times the OPSS payment is \$0.00. The total Medicare facility specific reimbursement amount for this line is \$5,774.26. This amount multiplied by 200% yields a MAR of \$11,548.52.
 - Procedure code J0171 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J7030 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
3. The total allowable reimbursement for the services in dispute is \$15,447.92. The amount previously paid by the insurance carrier is \$13,517.97. The requestor is seeking additional reimbursement in the amount of \$1,799.65. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,799.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,799.65, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 16, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.